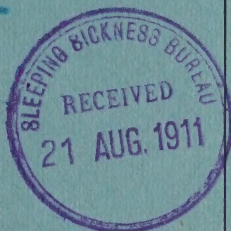


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A Case of Oriental Sore (Dermal
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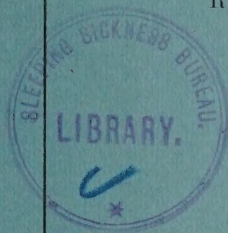


S. T. DARLING, M.D.

AND

R. C. CONNOR, M.D.

ANCON, CANAL ZONE



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A CASE OF ORIENTAL SORE (DERMAL LEISHMANIOSIS) IN A NATIVE COLOMBIAN

S. T. DARLING, M.D., AND R. C. CONNOR, M. D.
ANCON, CANAL ZONE

Oriental sore (dermal leishmaniosis), a disorder endemic in the Levant and the East, has been detected in a few localities in the New World: São Paulo and Bahia, Brazil, French Guiana and Panama. When the latitude and climate of the Oriental countries where the sore is endemic are considered, together with the fact that the autochthonous disorder is present in the New World, so far having been detected between 23.5 S. and 8 N. latitude, it is natural to presume that the disease will be found in Central America, Mexico, and some of the southern states, when especially looked for. A case of autochthonous oriental sore was discovered by one of us (S. T. D.) in the Canal Zone and renewed efforts have been made to find other cases and to ascertain if some have been overlooked in the past.

These facts should be noted by practitioners and laboratory workers in the southern states and seaport cities where examples of this type of ulceration may be encountered. They must also be taken into consideration in the diagnosis of all chronic ulcers in this region. Film preparations from ulcers on exposed parts of several months' duration should be carefully examined for the presence of the pathogenic agent of Oriental sore (*Leishmania tropica*). A preliminary experience with the cultural forms of trypanosomes or with insect flagellates—*Herpetomonas* or *Crithidia*—is helpful in knowing what to search for when the microorganisms are sparse.

Specific diagnosis is important because the infection is undoubtedly transmitted by flies or mosquitoes and the ulcers should be properly treated and protected by dressings from the visits of suctorial invertebrates.

The case reported here is the third one found to date and illustrates certain peculiar features of the disease: the chronic eroding character of the ulcer, its location on an exposed part, the presence of a second ulcer near by (auto-inoculation), the history of a fly-bite, and the

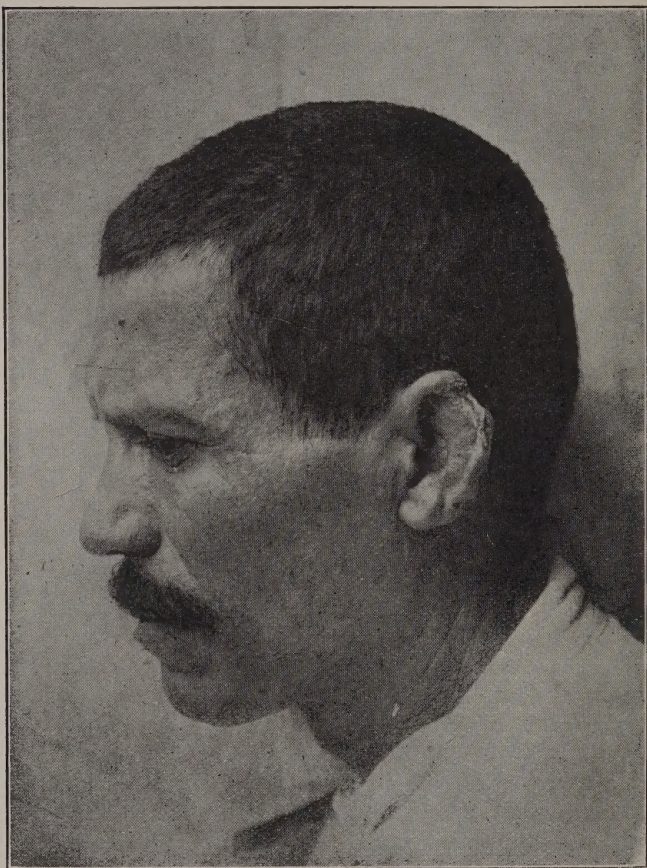


Fig. 1.—Patient with oriental sore on left ear.

difficulty experienced in this case in finding the pathogenic agent.

It should be mentioned that each one of the three patients affected with this disorder who have been examined up to date gave a history of being bitten by a fly

out in the bush. No case has arisen as yet within the zone of sanitation.

CASE REPORT

History.—A. V., Hospital Number 88,593; aged 43; native Colombian laborer; born in Cartagena, came to Panama during the régime of the Compagnie universelle du Canal inter-océanique, and has lived continuously in Panama for twenty-two years. Recently he had been working with surveying parties in the bush near Frijoles. He was admitted Nov. 25, 1910, with well-developed pulmonary tuberculosis. The peculiar lesions on his left ear were examined on two occasions for the presence of *L. tropica* and on the occasion of the second examination after a crust had been permitted to form, a few characteristic microorganisms were detected.

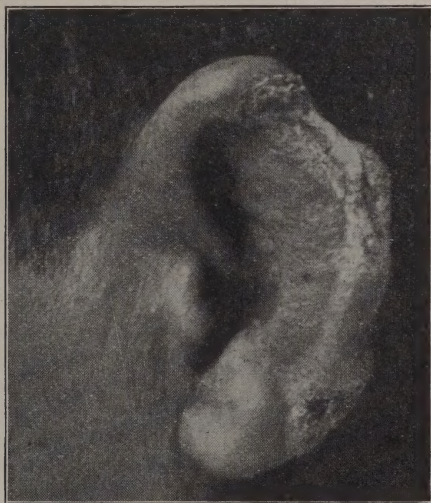


Fig. 2.—Closer view of oriental sore.

Examination.—When seen December 21, his left ear was of a dusky, brawny color, somewhat swollen, and the skin rather tense. The margin of the helix was eroded for about 3 to 4 cm. and covered with a depressed, tough, dry crust. At its junction with the lobule there was a second smaller ulcer, circular in shape, about 1.5 cm. in diameter, covered with a flattened tough crust (auto-inoculation). The appearance of the ulcers was suggestive of lupus or rodent ulcer and of Oriental sore. A protective dressing of boracic acid ointment was applied constantly and some improvement in the appearance of the lesions was noted, but the infiltration of the margin of

the skin about the ulcers increased. The patient refused more radical treatment on account of his feeble health.

The larger ulcer made its appearance, according to the patient, six or eight months before the date of his admission to the hospital. He believed that it followed a fly-bite, but on inquiry about the variety of fly and additional circumstances connected with the development of the sore, rather a fanciful statement was made by the patient. This is given as it conveys the natives' notion about the cause of this chronic type of skin ulceration.

The fly which the natives believe causes the ulceration is called by them *mosca bayano*. This fly, they say, is found only in the woods in the large yellow flowers of the bayano, a jungle plant. It was impossible to get from the patient a very exact idea of the kind of fly. When shown a number of specimens of *Tabanus*, *Musca*, *Stomoxys*, *Pyrellia*, *Comptosomyia*, and others, he thought the fly was about the size of *Stomoxys calcitrans*, but when he described its habits he said that on approach, the flies darted away so quickly that one could not make out either color or markings. Again the patient said that the fly did not really bite or draw blood, but deposited white feces which made the skin rot.

After the visit of the fly the place began to itch, a blister formed, which was scratched considerably, increased in size and became purulent. An ulcer soon appeared, which, with each removal of the scab, became deeper and larger.

Whatever the mode of infection may have been, there is no doubt of the cause: smears taken from just beneath the raised margin of the crust, when stained by Hastings' and Giemsa's stains, contained a few intracellular and extracellular specimens of *L. tropica*, exactly like those described in the case to be published by one of us (S. T. D.) in the *Archives of Internal Medicine*.



